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COMMENTS ON THE REPORT OF THE COMMITTEE ON PSYCHIATRIC STANDARDS AND POLICIES OF THE AMERICAN PSYCHIATRIC ASSOCIATION

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In the past one hundred years the American Psychiatric Association has assumed the great responsibility of creating policies and standards for the care and treatment of the mentally ill, as well as fostering research work for the prevention and treatment of mental diseases. The American Psychiatric Association has followed more or less a conservative approach for such achievement. However, in recent years the Association became cognizant of the fact that the attention of the entire nation was focused upon the need for adequate preventive and curative mental health services for all the people and that there was a definite demand for such hospital and out-patient services within the means of all classes of society.

The American Psychiatric Association recognized the fact that adequate psychiatric service has not been available to the mass of our population. It is very common not to find a psychiatrist within a radius of over one hundred miles. Most of the psychiatrists are located in large cities and in mental hospitals. Psychiatric service rendered by hospitals and clinics has never been on the same basis as the services of other branches of medicine in general hospitals. It was recognized by the Association that complete reorganization of hospital and out-patient services will be necessary. A uniform requisite for admission of patients to mental hospitals should be considered as vital. Outside of a few the majority of cases should be considered on a voluntary admission basis. Through education, such a procedure will become a rule rather than the exception. The Association felt that state hospitals for mentally ill should be so well planned that the public will accept them on the same basis as general hospitals. It is obvious that such services can be rendered to the people only through a competent staff. A true medical and psychiatric service can be rendered to the patients of our hospitals through competent personnel which cannot be obtained in any state without consideration of salaries of such a personnel. The Association became greatly concerned about the standards related to clinical activities. In the majority of our hospitals the most skillful psychiatrists are relegated to administrative responsibilities while the person to person treatment to our patients was delegated to the younger and less experienced staff members. The Association felt that it should be organized on such a basis that the service will radiate from its central headquarters to the whole of the United States as well as Canada and other countries of our hemisphere.

MENTAL HOSPITALS SHOULD LEAD THE WAY

Although marked strides have been made in hospitals for mental diseases in the last twenty years, the institutions have not reached the highest ideals and in the past four years have deteriorated considerably due to lack of personnel and equipment. Most of the hospitals in the country should be reorganized and restaffed.

The adequate recognition of psychiatry depends on standards created by mental hospitals and clinics, since all medical services emanate from the hospitals. Every recognized psychiatric hospital should be so well planned that the medical man and the public will accept them, thus public trust and confidence of the medical profession will be established. Such service can be rendered to the people only through a separation of the acutely and subacutely ill, as well as convalescent cases, from the chronic. Approach-

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ing this situation very realistically, it was felt that every hospital should assume the responsibility of excellent care and treatment of acutely ill by a competent staff of psychiatrists, well trained graduate male and female nurses and such other aides as are deemed necessary, thus giving the patients a great opportunity for recovery. *The cost for such care should be considered on the same basis as the cost of the physically acutely ill in an approved general hospital.* It is also deemed essential to *include* the cost for such services in the policies of the *"Blue Cross" and other hospital insurance plans.* The establishment of such a department in each mental hospital will institute a much greater bond with all general hospitals, medical schools and practicing physicians, thus stimulating a very desirable and badly needed understanding of mental health by the public. It is quite obvious that we are in an especially important era in regard to psychiatry. Never before has there been so much interest among medical men and lay people in psychiatry. Naturally the war and postwar conditions have stimulated this interest to a great extent and men are wanting instruction in psychiatry—men who would like to go into psychiatry, who have had general training in medicine. It is evident that this calls for a new reorganization in our concepts of psychiatric teaching and in the type of service that should be organized in the community. There should be a new integration of state mental hospitals with general hospitals and medical schools.

The Association advocates that there should be a psychiatrist on the staff of every general hospital of a certain size, to do consultation work, not only of the traditional psychiatric nature, but also to help with the psychoneuroses and psychosomatic medical cases, both on the surgical and on the medical wards. They should also be available for outpatient work, thus increasing the preventive work. There should be a new type of relationship between the general hospitals and state hospitals. The medical schools should supply men from their staffs to do teaching in state hospitals. This could be in the nature of seminars, discussions of case readings, bedside teaching and lectures. The senior men in the state hospitals should receive appointments on the teaching staffs of our medical schools.

The Association hopes also that some time before a degree in medicine was granted, each student would have had to serve some weeks on the staff of a state hospital doing practical clinical work.

The new standards for psychiatric hospitals and out-patient clinics prepared by the Committee on Psychiatric Standards and Policies were approved and adopted by the Association and published in the American Journal of Psychiatry, Vol. 102, No. 2, Sept. 1945. In the opinion of the Association the standards apply to large state hospitals and not to small institutions, particularly those connected with medical schools. It is obvious that these small teaching centers should be well-staffed and should carry on teaching and research work as well as have high standards of psychiatric care. One cannot expect these standards exercised literally in such teaching and other small hospitals.

STANDARDS FOR PSYCHIATRIC HOSPITALS

1. "All hospitals should have a small unit or department which will take the place of the present receiving ward, where patients upon admission will remain a brief period (usually not to exceed two weeks) to be classified and housed according to their condition. This unit will require the services of a psychiatrist for every 30 patients under observation; a graduate nurse for every 4 patients and a trained attendant for every 6 patients under observation.

2. "Approved hospitals should have a special unit or department for acutely mentally ill, where a patient will receive individual medical, psychiatric, nursing care and treatment, and individual services in the field of occupational, recreational and allied therapy. Intensive psychotherapy, in conjunction with physio-hydro-therapy, as well as modern organic therapy must be considered as indispensable in each case. The size of such a unit should accord with the admissions within a three to six months' period. This unit will have a small sub-unit for disturbed acutely ill individuals who will receive the same individual care and treatment.

"All cases in the unit for acutely ill should be housed either in single rooms or in small dormitories. Such a unit will require a psychiatrist for every 30 patients; a graduate nurse for every 4 patients; a trained attendant for every 6 patients; a physio-hydro-therapist, an occupational-therapist, and a recreational therapist for every 30 patients requiring such treatment, and any other service indicated.

3. "Hospitals should have a unit or department for a convalescing group where a patient will receive somewhat similar care, although not requiring as intensive treatment as in the unit for the acutely ill. The size of such a unit will be determined by the number of home convalescing patients during a period of six months. Such a unit will require a psychiatrist for every 50 patients; a graduate nurse for every 10 patients; a trained attendant for every 7 patients; an occupational therapist for every 30 patients; a recreational therapist for every 50 patients, and any other service indicated.

4. "Hospitals assuming responsibility for patients with a favorable prognosis but who require intensive prolonged treatment and care should have a unit or department for such patients. Such a re-educational service will require a psychiatrist for every 75 patients; a graduate nurse for every 25 patients; a trained attendant for every 8 patients; a physio-hydro-therapist, an occupational therapist and a recreational therapist for every 75 patients, and any other service indicated. This unit will have a special sub-unit for chronic disturbed patients.

5. "Hospitals receiving patients who require continued treatment should have a special unit or department. Such a unit will need a psychiatrist for every 200 patients; a graduate nurse for every 40 patients; a trained attendant for every 6 patients; a physio-hydro-therapist for every 200 patients; an occupational therapist for every 50 patients; a re-educational therapist for every 50 patients; a recreational therapist for every 100 patients, and any other service indicated.

6. "Hospitals receiving senile and arteriosclerotic patients, should have a special unit or department for such patients. Such service will require a psychiatrist for every 200 patients; a graduate nurse for every 50 patients; a trained attendant for every 8 patients; an occupational-recreational therapist for every 100 patients, and any other service indicated. This department will also include a special infirmary section with a graduate nurse in charge.

7. "Hospitals should have a special unit known as a medical and surgical department for patients who are actually physically ill, requiring either medical or surgical treatment. This unit will require well trained physicians, who have had adequate experience in general medicine and general surgery, with some psychiatric background. This unit should meet minimum standards of the American College of Surgeons.

8. "Mental hospitals receiving children under 16 years of age, will require a special unit or department known as the children's unit. Such a unit will require the service of a psychiatrist, who has had training and experience in a child guidance clinic, and preferably pediatrics, for every 30 children; a graduate nurse for every 10 children; a trained attendant for every 7 children; a teacher for every 20 children; an occupational-recreational therapist for every 30 children; a physio-hydro-therapist for every 30 children; and any other service indicated.

9. "If a mental hospital receives alcoholics and/or other drug addicts, it should have a special unit or department for their care and treatment. Such a unit will require a psychiatrist for every 25 patients; a graduate nurse and a trained attendant for every 8 patients; a physio-hydro-therapist for every 25 patients; an occupational therapist for every 50 patients; a recreational therapist for every 30 patients; and any other service indicated.

10. "Mental hospitals should have a special unit or department for tuberculous patients. Such a unit will require the services of a physician experienced in the field of tuberculosis for every 75 patients and a psychiatrist for every 100 patients; a graduate nurse for every 5 patients; a trained attendant for every 6 patients; an occupational therapist for every 25 patients, and any other service indicated.

"No institution can be considered a modern hospital unless it has adequate facilities for all types of physical examinations and tests required by the American College of Surgeons, including well organized clinical and pathological laboratories under competent direction; a roentgenological department; and a medical library under supervision of the clinical director.

"Every approved hospital should be under the management and direction of a superintendent, who should be a well qualified physician and experienced psychiatrist with administrative ability, whose appointment and removal should not be controlled by partisan politics. In hospitals with a population of more than 1,000 patients there should be an assistant superintendent, who should be an experienced and well qualified psychiatrist as well as a good administrator.

"Since adequate service can be rendered to the patients only through a competent staff, it should be imperative for every mental hospital to have a very well trained and experienced psychiatrist as clinical director, who will be the coordinator and stimulating head of the medical staff, and who will organize systematic instruction and rotation of service for the members of the staff. He should institute and supervise seminars for scientific discussions at frequent intervals. Staff meetings should be held at regular intervals, not less than once a week, under the direction of the clinical director.

"It is desirable that the superintendent or medical director, the assistant superintendent and the clinical director should be diplomates of the American Board of Psychiatry and Neurology.

"Salaries for the above positions should at least be comparable to those of specialists in other fields of medicine in the respective communities.

"Every member of the staff of each hospital should be encouraged to devote a certain number of hours per week to research or scientific study and investigation.

"It is desirable that every mental hospital have a well organized department of clinical psychology.

"All nursing, including attendants, in the mental hospitals must be placed under the director of nursing, who would be responsible to the individual authority of each service, to the clinical director and the superintendent of the hospital.

"It is desirable that the director of nurses should be a graduate of an approved school of nursing affiliated with a general hospital, who has the degree of Bachelor of Science of Nursing Education or its equivalent, and who has had a post-graduate course in psychiatric nursing in a recognized hospital. She should have had at least five years' experience including special training in administration.

"It is desirable that every mental hospital should have a training school for nurses wherever possible, as well as affiliate nursing courses.

"Mental hospitals should attempt to have a larger corps of well trained psychiatric nursing instructors. Many hospitals have been impeded and retarded in their educational programs for nurses and attendants by the scarcity of properly qualified instructors. It is suggested that every hospital should attempt to develop a post-graduate course for such instructors at the university level, wherever possible, and under the control of the universities using mental hospitals for practical training.

"Every approved hospital should have a minimum of one trained social worker for every 100 annual admissions, under the direction of a chief, who will so organize the department that there will be adequate pre-admission, admission and follow-up services.

"Psychiatric social workers should be graduates of an approved school of social work with at least 800 hours of supervised work experience in a psychiatric agency.

"The chief psychiatric social worker should have had three years' additional professional experience, at least two being in a psychiatric hospital and clinic.

"Every mental hospital should have the services of a well organized dental department, under the direction of a well qualified dentist.

"Every hospital should have the services of a well organized department of pharmacy.

"All non-medical administration duties should be rendered through a special service

department, headed by the proper medical officer or business manager, under direction of the superintendent.

"The medical record system in a mental hospital should be under the supervision of a medical records librarian, fully qualified and if possible accredited by the American Association of Medical Record Librarians.

"Every hospital should have a regular library for the patients, under the direction of a librarian."

The Association feels that every well thinking administrator of psychiatric hospitals, as well as the vast majority of psychiatrists, will wholeheartedly support this approach of the American Psychiatric Association. However, this will not be sufficient to carry out the program for the ideal plan for psychiatric service. It will be necessary for the organized medical profession through its many channels, to induce the public as a whole to become cognizant of the importance of this program and to prepare their representatives to think seriously how to make this program a reality.

The American Psychiatric Association urges every state mental hospital to consider a minimum of five dollars per capita per diem necessary for the care and treatment of acute, sub-acute and convalescent cases and two dollars and fifty cents per capita per diem for the care of various types of chronic cases.

THE NERVOUS VETERAN, A Preliminary Study of Causes*

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The problems of nervousness, emotional instability and maladjustment have been receiving increasing attention in both medical and lay literature. They were given impetus during the war, first, because of the large number of our young men rejected from military service for neuro-psychiatric reasons; and second, due to the large number of men discharged from the service or assigned to non-combatant duties by reason of their inability to adjust to the stresses of military life.

Many theories have been advanced and much has been written about the nervous soldier. As yet we have no satisfactory answer as to why one person can adjust where another fails. This problem is not only one of military interest but important to the whole country. Because of the number of beds occupied by mental patients, and the large number of persons unable to function efficiently in our social structure, it is vital that every effort be made to uncover and correct the cause of this economic disaster: mental illness.

This study is but a preliminary investigation on a relatively small number of cases, undertaken with the objective of finding some clues, some guide-posts, to lead us further in the knowledge of the origins of maladjustments and the neuroses. We have selected forty-five neuropsychiatric cases from the files of the Veterans' Traveling Convalescent Clinic for study; the criteria being, that each case has been studied both psychiatrically and psychologically so that there may be an objective approach to the problem.

Among the cases studied only three were colored. This ratio of race is disproportionate to the population figures of our state. The discrepancy can probably be explained by the fact that the colored people were less aware of the clinic services and significance. It is not necessarily an indication of the relative frequency of disability.

The youngest patient was nineteen and the oldest forty. Two were in their teens, 31 between the ages of twenty and twenty-nine and and the remaining 12 were in their thirties. This proportion coincides with the reported age ratios in military service allowing for the fact that one or more years have elapsed since these persons were inducted. Of those under thirty years of age, 65% were single and of the remainder one was divorced. In the age group above thirty, ¾ were or had been married and 1/3 of these were separated from their wives.

Separation from the home and a foreign environment have been offered as causes for many of the breakdowns in military service. In the group studied we find that 71% gave

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a history of nervous symptoms or maladjustment prior to entering the service and the majority of these served in this country only. In our series only 38% had been overseas and, of these 17 cases, 4 had had symptoms before entering the service, 11 developed symptoms in the service prior to leaving the country, and only 2 had typical combat reactions.

One of these, #94 G. V. C., was a twenty-one-year-old white youth, whose father had drunk to excess and died in a state hospital, and whose parents had separated when G. was less than two years old. He was raised by his mother, and from his description was abnormally attached to her, "a mother's boy." G. is of average intelligence but only received six years of grade school education and has been employed as helper and truck-driver prior to entering the Service.
G. denies any nervous symptoms until after he had served with an armored unit in Europe. In 45 days of combat, during which he was strafed, bombed and shelled frequently, he became restless, jittery, lost his appetite and suffered disturbed sleep. He had a comparatively minor vehicle accident but now complains of many resultant somatic disabilities. In addition, he continues to suffer from battle dreams, rolling and tumbling in his sleep, startle reactions to loud noises, tremulousness, anorexia and inability to mingle with others. G. was considered to be an emotionally immature and dependent personality, suffering from combat reaction.

Among the cases studied, the diagnosis of psychoneurosis or one of its sub-groups was made in 58%. 22% were considered to be either inadequate personalities or simple adult maladjustments. The remainder included epilepsy, cerebro-spinal syphilis, and dementia praecox. These last named had been discharged from the service because of their illnesses. One veteran had been discharged because of nephritis. Two cases, or 5%, had received discharges without honor because of alcoholism and maladjustment. 26% of those studied had received medical discharges for other neuropsychiatric reasons. Analysis of the case histories of the last group reveals that more than half had definite symptoms prior to entering the service.

#87 N. G. W. was referred for nervousness and insomnia which he related to frequent attacks of malaria while in the service. This twenty-five-year-old white youth had been previously known to the Mental Hygiene Clinic when, at the age of fourteen, he was examined because of his troublesomeness in school where he was noisy and refused to obey or conform. N. is one of nine siblings whose mother related that ever since he had struck his right temple when he fell on the ice, at about the age of seven years, he had been a very nervous child. When interviewed N. related that after he left school he had had difficulty finding satisfactory work, as he was a "wood specialist" and most shops were so noisy that they "got on his nerves and made him jittery." Probably because of his difficulty in social adjustment, N. sought security in the Army prior to Pearl Harbor. As a regular Army man, stationed in the Pacific, N. was subjected to the original December 7th raid, as well as 180 bombing attacks, usually at night. He also served about 40 days on the Guadalcanal hills exposed to snipers and shell-fire before being evacuated for nervousness. He relates that he was not particularly scared until a close bomb hit killed 8 of his friends and, following this, he found himself crying and tremulous. He was diagnosed as combat reaction.

In breaking down the predominance of symptoms as presented by the patients at the time of their initial interview, we note that anxieties were most prevalent, being listed 14 times. Headaches of a conversion type, tenseness and tremulousness were next, followed by complaints of depression, disturbed sleep, irritability and anorexia. Somatic complaints, such as low back pain, nervous stomach and weakness, were next most frequent, in company with impulsiveness, quarrelsomeness and impaired concentration.

During military service we were impressed by the apparent relation between lack of education and nervousness or maladjustment. But in this study of a small group from a rather representative cross-section of our country, we note that only 6 cases had less than an eighth-grade education, while 56% had either graduated from grade school or had some high-school education, and 31% had graduated from high school or had one or more years of college. In this respect psychological testing revealed that 85% were of average intelligence, 5% borderline and 10% of superior intelligence.

Another factor which has been presented as causative in mental illness is that of the broken home. We found only 40% could be said to have come from unsatisfactory homes. Evaluation of this figure depends upon an understanding of the criteria used. We employ the term only when brief interrogation reveals that the patient was from a home which had been broken by the death of one or

the other parent, a home disturbed by separation, divorce, drinking, or mental illness, or a home considered unsatisfactory because of marked over-indulgence, protection or rejection of the patient.

#19 C. T. K., A typical example of an unsatisfactory home and its effect is shown in the case of C. whose father had been drinking to excess as long as C could remember and his parents separated when C. was twenty-three. Because of the father's alcoholism he never adequately supported his family and frequently embarrassed them by his behavior. The paternal grandparents had separated and 2 paternal uncles had been state hospital patients. It is reported that during C.'s childhood he had occasional night-terrors and nightmares but otherwise his development is described as normal and he had always been a "good boy." Throughout his life C. was backward and "does not take up with everybody," apparently shy and seclusive.
Shortly after enlistment in the service he had a rather severe inoculation reaction, following which he developed many somatic complaints, anxieties and loss of self-confidence, so that after discharge he was unable to return to his previous employment.

Analysis of the social adjustment, excluding neurotic traits, revealed no significant difference between those from unsatisfactory homes and those from apparently good environments; in fact, the incidence of alcoholic excess was twice as great among the latter.

From the experiences in World War I and those of our Allies before we entered the recent conflict, the military had concluded that morale was a very important factor in preventing mental breakdowns or maladjustments. Military morale can be analyzed either as a transient state of enthusiasm brought about by pep talks and propaganda; or it can be somewhat more permanent because of the prolonged training in understanding of causes and effects, unit pride and identification, with respect and admiration for leadership. Or, then again, morale may be based on more deepseated factors, such as social motivation, volition, will-power and the desire to be socially constructive.

In this study the factors of motivation and volition were analyzed as determined objectively in the psychological test pattern. It was found that 65% of the cases had appreciably diminished scores, indicating low volition and motivation, as compared to other scores. Of this group more than half had symptoms before entering the service. About 50% of those considered low in drive were diagnosed neurotic and 35% maladjusted or inadequate persons. Of the remainder, 2 were diagnosed as psychotic and another as epilepsy associated with chronic alcoholism in a badly maladjusted personality.

Since this psychological factor of low motivation seems to be so important, a comparison with the group having normal will-power is in order. Comparison of intellectual capacity in this small group was not contributory, as all those of borderline intelligence revealed good volitional qualities, whereas, all of low-average intelligence were low in motivation. Three-fourths of those with average scores and a little more than ½ of those of high-average intelligence revealed poor willpower. But only 1/5 of those in the group of superior intelligence had low willpower. Five had less than an eighth-grade education, 15 had graduated from grade school or had some high school training, and 8 had graduated from high school or had one or more years of college.

The home environment and possibly heredity, because the parents make or break the home, appear to be the most significant factors. Forty-seven percent of those revealing low volitional factors came from obviously unsatisfactory homes as compared to 29% of the other group. In each group 18% admitted to excessive indulgence in alcohol. Thirty-two percent of the first group admitted to poor work records, while none of the others did. Both groups were equal in the number of broken marriages.

In the large group which had revealed evidence of maladjustment prior to entering the service, about 70% had low volitional scores.

When considered as to diagnoses, we note that those whose psychological pattern indicates poor volition are about evenly divided between neuroses and maladjustments. Whereas, our figures show that where motivation scores were good, only one case was considered to be a maladjusted person, and he was of borderline intelligence, from a broken home, with a long history of delinquency.

#66 B. Z. A twenty-six-year-old male, of Polish descent, had been known to the Mental Hygiene Clinic thirteen years previously. At that time he was examined at the request of the Juvenile Court because of malicious mischief. We note that he is the youngest of 3 siblings. His parents had separated and the mother remarried only to separate again. B. was found to be of borderline intelligence, with an attitude of indifference about his offense and its significance. He was re-examined three years later by which time he had added four more offenses, including larceny, to his record. He related that he had attended school through the eighth grade, following which he had had many different jobs, changing either because of arguments with employer or because he just didn't like them. He stated that he had a defective toe amputated so that he could enlist in the service, but in spite of his apparent good intentions did not adjust well. He was frequently transferred to various units and readily admits having been AWOL ten times and courtmartialed three times. He was hospitalized in the Army for seven months for nervousness prior to receiving an honorable discharge.
B. complains that he worries about things, becomes easily irritated and says things that he does not mean. His examination revealed marked vasomotor instability and he was diagnosed as emotionally unstable, inadequate personality.

Continuing further with the pattern analysis, we observed impaired reasoning in only 13% of the cases and these were all characterized by severe anxiety. A typical introversion pattern was observed in 2, 1 of whom had been diagnosed at the Mental Hygiene Clinic as pre-schizoid prior to entering the service.

SUMMARY

By reason of the large number of neuropsychiatric rejections and casualties in World War II, this problem is gaining prominence and attention and warrants an all-out effort to determine its cause and cure. This brief study attempts to provide through objective analysis a starting point for further research and reveals that age, race and educational level are not significant factors. Marital maladjustment was as expected, higher among the older age group.

Separation from the home environment was not in itself contributory, as a majority had revealed symptoms of maladjustment prior to entering service. Many did allege aggravation of old symptoms or the presence of new complaints which interfered with their adjustment and efficiency. Symptoms of anxiety and somatic conversion were the most frequently presented. The military services recognizes these disabilities and discharged 45% of our series for neuropsychiatric reasons, and permitted only about 1/3 overseas duties.

An objective analysis of the psychometric subtest patterns reveals that low volitional and motivation factors are present in a significant majority of those studied. Most of these had symptoms as evidence of maladjustment for many years and a disproportionate number were from unsatisfactory homes. There was no significant relationship between education, intellectual capacity and volitional traits. Psychiatric diagnoses were based upon clinical findings and we found that when motivational scores were satisfactory, the patients had been considered psychoneurotic; whereas 50% of those with low scores were diagnosed as maladjusted or inadequate personalities.

CONCLUSION

This preliminary study seems to indicate the need for further objective research into the relation of will-power and motivation to mental illness and social maladjustment. It indicates the necessity of reorganizing diagnostic concepts in accordance with total personality structure, and suggests that heredity or early environment is responsible for the outstanding personality defect—lack of volition.

PROBLEMS OF PSYCHIATRIC DIAGNOSIS

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While psychiatry has considerably advanced in scope and therapeutic effort, the psychiatrist continues to find himself in a somewhat awkward position in regard to his diagnostic problems. This is usually explained by the fact that his understanding of the personality problem runs far ahead of the standard classification in use, and that he is limited to pigeon-holing the case for statistical purposes. But it is certainly more than the standard classification that is responsible for the persistence of errors in diagnosis.

One cannot fail to note that erring is

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human, and that psychiatric diagnosis like any other human endeavor is beset with the frailties of all human effort. There are several reasons for diagnostic failures. The most elementary is the lack of congruity between the diagnostic label and the complexities of the biodynamics of mental deviations. This has been generally recognized as a serious drawback prone to detract the value of any formal diagnosis. Its defects become quite evident in borderline states which share essential characteristics of two or more groupings. Cases of schizophrenic reaction following malaria therapy of neurosyphilis, cases of general paresis with a schizophrenic pattern, and those not uncommon instances of affective-schizophrenic mixtures come to mind. But there is really not so much trouble with the attempt at classification as with the arbitrariness with which it is often made. There is always an easy way out of what seems to be a diagnostic impasse into the definiteness of simple group concepts on which all classification is based.

On close scrutiny the group concepts are rigid, but they cannot be too flexible because they are designed to be guide posts in a field where there are still too many unknown and unexplored areas. Rigid adherence to diagnostic labels has administrative advantages. One may not care to mix up the psychoneurotic reactions, the cyclothymic states and the involutional psychoses proper just because all are liable to occur at the menopausal phase. Yet many of the former conditions have unfortunately ended up under the heading of involutional psychosis. It is surprising, indeed, to find how little the organic or endocrinological factors amount to in such cases, especially when glandular therapy terminates in failure or when other methods are successful without the use of glandular therapy.

Naturally one cannot or should not allow therapeutic considerations to interfere with one's diagnostic concepts. From the viewpoint of therapy a psychopathic state may be intractable whereas a psychosis may be a therapeutic success. Likewise a precox case may respond excellently to electroshock treatment whereas a cyclothymic reaction may not. But one cannot state that a precox is not precox because so many, or so few, electroshock treatments have turned the tide of psychosis. Certainly such a stand cannot be taken as long as phenomenological criteria guide the diagnosis. Then, the evaluation of treatment success will not prejudice the diagnostician against thinking of a schizophrenic reaction as being favorable or benign as it most fortunately often turns out to be. Neither will it prejudice one against the diagnosis of dementia precox in general for considerations lying outside the patient's problems as for example considerations for his family, his friends, or his employer.

For the sake of scientific truth it will be wiser to keep psychiatric cases undiagnosed than to label them falsely. There should be no reasonable objection to any objective recording of facts, so there should be no reasonable objection to calling a spade a spade, or a precox a precox, whether favorable in outcome or not.

There are many labels toward which the psychiatrist may feel prejudiced for the sake of considerations outside the ken of facts. But it seems better from the viewpoint of policy to stick to the facts.

One may feel prejudiced against the diagnosis of psychopathy. In some places the diagnosis of psychopathic personality is shunned for reasons of avoiding social stigma, in others the same diagnosis is overworked to cover up ignorance of the multifarious aberrations of the mind.

Psychopathic states have their distinctive and universal characteristics the analysis of which should permit a balanced and objective diagnosis. Our methods of observation and examination will have to be improved by reference to a more highly differentiated trait classification with the aid of psychometric tests. Most current psychometric procedures are too short and unreliable to bring out the nuclear elements of the personality. Appropriate test interpretation lags far behind test administration, and such vague concepts as inadequacy, instability or maladjustment become diagnostic expedients.

Much more serious objections could be raised to the diagnosis of mental deficiency in many instances on objective grounds. The reason is that the mental deficiency group in-

cludes the most incongruous mixture of conditions which are still in need of etiological clarification. Furthermore, in the realm of subnormal intelligence, the stable and the unstable, the relatively well organized and the unorganized should be strictly separated. It is to be expected that under this label hide many instances of psychosis with no mental deficiency whatsoever. More accurate psychometric test methods are apt to eliminate the possibility of wrong classification in a group that appears especially vulnerable from the viewpoint of rash and superficial diagnosis followed by decisions of serious consequence such as relegation to an institution for the feeble-minded, neglect of etiological therapy, and worse yet, legalized sterilization procedure.

Much of the diagnostic difficulties arise from the lack of uniformity in the accepted diagnostic classification. Some terms are strictly etiological, others are strictly phenomenological. It is doubtless true that different individuals react to the same type of trauma, be it physical or mental, in a different manner. Thus, the reactions or the reactors appear more divergent than the etiologies. To whatever extent this fact may involve classification, a double or even multiple diagnosis will occasionally be inescapable. This would not constitute a setback as it becomes a more general custom to define the nature of the traumatic situation as dual or multiple from the standpoint of both cause and effect. The real trouble, however, begins at a point where the effect is known but not the cause, and where the etiological element is inadvertently or unknowingly misunderstood or misplaced.

While it still holds true that psychological mechanisms are credited with the development of abnormal mental patterns, their physiological correlates are barely known, and while the term "functional" is still adhered to for descriptive purposes, the somatic aspects are often pushed into the background with the result that subjective interpretation prevails over objective fact finding.

The progress of psychiatry will, of course, not alone depend on improved classification procedures, but on a more profound synthesis of data coming from the allied psychological field and from the biochemical and pathological laboratory. Psychiatry within its own sphere will have to set up non-overlapping criteria of comparison to promote multiple and differential therapeutic procedures wherever necessary.

EMOTIONAL VACUUM AND ALCOHOLISM

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The complex problem of alcoholism requires a very realistic attitude from the medical profession. A continuous re-evaluation of concepts is necessary, especially in view of the fact that alcoholism seems to increase far more rapidly than indicated by inconclusive statistics. The development of interpretative psychiatry has led to a current tendency to classify all alcoholics as "sick people" and to refer to alcoholism as a neurosis. This approach oversimplifies actual conditions at the expense of certain realities. A generalized presentation of the alcoholic according to which he is a conflict ridden individual who, unable to face or solve them, drinks in order to numb his troubled mind, would lead one to believe that an adequate therapeutic approach should be comparatively simple and effective. It has almost become a platitude to call the alcoholic an "escapist" who has to be induced to recognize his inner conflicts, gain insight and thus overcome his addiction.

Actualities, however, give very little reason for prognostic optimism and nothing would be more unjustified than satisfaction with the present therapeutic methods. It is of the greatest importance to have a realistic appreciation of therapeutic potentialities. Anyone who has sufficient experience with alcoholics knows that the majority of addicts relapse, regardless of the type of therapeutic management. Neither animal experiments, investigating the psychopharmocology of alcohol, nor dynamic interpretation of motives have been instrumental in improving the prognostic prospects.

It is evident that the diversity of personality types who become addicted to alcohol requires an individual approach rather than

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generalizing theories. It is nevertheless desirable to reduce the variety of etiological factors to groups with a common denominator.

The existence of psychopathological factors seems to have been over-evaluated and it becomes increasingly clear that a very substantial number of alcoholics cannot be regarded as "sick." An analysis of personality components and a search for repressed or unconscious conflicts generally fails to reveal any evidence of a neurosis. An ever increasing number of alcoholics can be understood only through recognition of sociopathological factors of which one of the most important one's can be defined as an "emotional vacuum." These alcoholics drink because, bluntly speaking, there is nothing else to do to break the monotony of their lives. Their problem, for instance, begins at 5:00 p. m. when they leave their offices and are on their way home. They face a vacuum. Lack of cultural interests, a sterile home atmosphere, marriage relations which have grown stale lead these individuals to the next cocktail lounge or beer garden. A crowd composed of such individuals is still much larger on Saturday at noon when the weekend looms ahead as a prolonged period of boredom and emptiness. Many people from all walks of life become alcoholics because drinking places offered the only existing diversion. This is especially true in smaller cities which completely lack any trace of cultural activities and where movies seem to be the only source of enlightenment or entertainment.

It will be said, of course, that it is up to the individual and his capacity for experiences to evaluate life situations as dull or fascinating. While this fundamental truth cannot be contested, it must be added that monotony can be a reality and does not merely reflect an individual's lack of capability to interest himself. An emotional vacuum as a mass phenomenon is a sociopathological problem which points toward the existence of a cultural crisis. It simply means that a vast number of people completely lack a philosophy of living. The recognition of sociopathological aspects of alcoholism has certainly been neglected in the contemporary literature. The only social factor which is commonly discussed, is economic insecurity and its relationship to inebriety. The last few years of relative prosperity have produced a rapid increase of alcoholism—a fact which seems to minimize the importance of economic insecurity as an etiological factor. A primary cultural theory of an essential aspect of alcohol addiction is overdue for acceptance in psychiatric thinking.

Psychiatric analysis of any personality may reveal certain factors which may seem to be of potential psychopathological significance. In dealing with these factors, however, our outlook should be psychiatric, not psychiatristic. The mere existence of latent psychoneurotic trends is non-explanatory pertaining to the etiology of alcohol addiction.

Experiences during the war have re-emphasized the time honored knowledge of relations between general morale and mental stability. Reliable reports disclosed that the incidence of psychoneurotic reactions in the armed forces was smallest in groups with good leadership. Many psychiatrists seem to feel that considerations of interrelationship between general morale and the alcoholic individual is of little value as it does not contribute to the therapeutic problem which, after all, is confined to the individual. The alcoholic patient, however, must not merely be considered as an individual but also as a social person. The therapeutic management in its last and final stage cannot avoid the responsibility of reorienting the patient's outlook toward life. This is undoubtedly the most crucial, most difficult, most responsible and most neglected aspect of therapy. It is useless to focus attention exclusively on analysis of personality factors and the development of insight if the patient remains bored with life. Since the physician cannot assume the role of educator, minister or philosopher, his only approach to this problem is usually one of so called "substitutive treatment" consisting of suggesting hobbies and various occupations. Since it is fundamental to direct the patient at new emotional experiences, a recreational and educational therapy can be tremendously helpful. In the majority of cases, however, these measures are not sufficient to stimulate

a new affection or reorientation of the inner attitude toward life.

The more fundamental solution to this problem lies in re-education. While the concept of re-education has become a familiar tool in psychiatric language, it is hardly more than a vague phrase and is not based on any real pedagogic principles. The chief goal of any educational effort should be the development of emotional maturity, self-discipline, personal and social responsibility. These qualities represent the stigmata of any cultural society. The designation of "lack of will power" as a causative factor of alcohol addiction has figured prominently in the literature on this subject. During recent years the discussion of this factor has been more or less abandoned either because it was felt that it is too vague and lacks psychological differentiation or because it smells suspiciously of moral judgment. These observations are undoubtedly based on sound reasoning. The fact remains that there exists a human attitude of lack of will power which manifests an absence of conviction, aim and purpose. An increase of this attitude in a society must be related to inadequate education. The great Hellenic teachers and philosophers knew this and directed education at the development of strong characters which they conceived to be the prerequisite for the functioning of democracy. If one compares their superior philosophy with the current ideas on so called "progressive education" one may be led to reorient one's concepts on mental hygiene. Modern pedagogy has been influenced by badly misunderstood psychiatric theories. Ever since the concepts on repression and inhibition made their way into the general literature, educators arrived at the fallacious conclusion that any kind of discipline would be harmful and should be banned as radically as possible. Not long ago a prominent member of the staff of a child's guidance clinic remarked in a speech to parents that discipline was not only psychologically harmful but also "undemocratic." Psychiatrists have neglected to explain that while repression and inhibition are under certain circumstances causative factors in psychopathology, they are also necessary fundamental elements in the human personality and are essential for the development of the cultured person. Social responsibility in a democracy depends on these virtues. Would it be heretical to say that the study of the Hellenic philosophy on education could contribute an immensely richer and sounder material to the subject of mental hygiene than a vast number of current articles and pamphlets? Francis J. Braceland in a recent speech on "Psychiatry and the Returning Veteran" emphasized "that psychiatry has its limitation and that its tenets are not applicable to all fields of knowledge." If it comes to education, or for that matter re-education, psychiatry must take its knowledge from the pedagogic sciences, whereas, in reverse, there is very little that psychiatry can contribute to the subject of education.

Will power as a psychological phenomenon cannot be separated from any kind of educational task. Psychiatry, in spite of the hopes of optimists, will never be able to cure the ills of society. Psychiatric treatment taking the form of re-education must be reinforced through contact with other intellectual forces. The establishment of interest, enthusiasm and affection can be achieved in the members of any group or society in which cultural activities, of whatever nature they may be, permeate the public atmosphere. Enthusiasm and the aroused sense of social responsibility can completely replace the emotional vacuum of the alcoholic. Abraham Myerson mentioned the case of a man whom he had to examine in a camp in World War I. This man was supposed to be a psychopathic drunkard and was recommended for discharge from the Army, but while the technicalities of discharging him were being unwound, his regiment moved to France and he became one of the greatest heroes of the American Expeditionary Force. Since re-education cannot be exclusively or successfully built on psychiatric concepts, one may seriously explore the possibilities for setting up re-educational clinics for alcoholics where, in addition to psychiatrists, representatives of various cultural forces would construct a program of systematic re-education.

If committees and organizations on Mental Hygiene want to approach the problem of alcohol addiction on a realistic basis, they have to impress society with the fact that the so-

cial element, or rather the sociopathological factor constitutes one of the basic causative forces. No longer should the average alcoholic be presented as someone who "runs away from something." It should be stressed instead that alcoholism is closely linked with social factors and that its geographical distribution, for instance, depends on cultural patterns. Psychiatrists and their various aides have to keep in mind that psychodynamic factors operate just as effectively in people of nations or cultures with a low incidence of alcoholism as in those among whom the number of addicts is excessively large and continues to increase.

In treating the alcoholic individual no psychiatrist should fail to study all aspects of his patient's life situation. The therapeutic management, at first clinical, later psychological, must in its final phase combat the emotional vacuum through reorientation of patients' attitude toward life. Only those who fully appreciate the difficulty of this task will have a realistic comprehension of therapeutic potentialities in the treatment of alcoholism as a mass phenomenon.

"PROLONGED ELECTROCONVULSIVE THERAPY"

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Electroshock therapy has become known to be the most harmless and the most widely accepted form of shock therapy in the psychiatric field. It combines comparative safety if applied to a carefully selected material, with easy applicability and a saving of time and energy to the supervising personnel. Its success has been firmly established in the treatment of certain types of acute psychosis such as cyclothymic and involutional depressions and some forms of dementia praecox. By contrast, it has failed to achieve significant results in certain types of neurosis, in the hebephrenic and simple type of schizophrenia, in paranoid condition, in the psychoses associated with mental deficiency and psychopathic states.

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The handicaps imposed by the war situation due to lack of attendants and nurses and to the need for efficient short-cut methods in the handling of a type of patient considered refractory, chronic and custodial, inevitably led to the acceptance of the electro-convulsive treatment as a valuable aid in overcoming those difficulties which would formerly have called for extensive and prolonged application of such conservative methods as hydro-, narco- and psychotherapy alone or combined.

The symptomatic relief afforded by electroshock treatments was early recognized even in cases which ultimately did not react favorably. Noisy patients would, thus, become quiet, and destructive reactions subside under the impact of a short series of treatments although no definite hope for permanent change could be held out in view of the distinct evidence of previous treatment failures.

At first there existed a considerable reluctance to the forced repetition ad infinitum of the electroshock seizures as an agent of symptomatic relief. The possibility of damage from the electric current used in this type of treatment had to be seriously considered and still is a controversial issue. But in spite of the anticipation of some complication, there apparently has been no demonstrable evidence of any ill effect that would allow the justification of an alarmist attitude. That electroshock treatment can be pushed to an extreme without apparent harm, if skillfully handled, is testified to by the experience of other clinical observers. Although we are fully aware of the liability to severe criticism, such strenuous efforts seem at times to entail deserved rewards both for the patient and for the therapist, and, it is rather a matter of perseverance that perhaps in the end, brings quite unexpected results.

Each of the following cases is designed to show the merit of persistence in the application of shock treatment for definite objectives.

CASE I

F. H. is a white female, 46 years of age. She was committed to the Delaware State Hospital in 1931 with catatonic symptoms. Her father was alcoholic and nervous, and one brother was addicted to alcohol. Patient attended business college and worked as a stenographer, bookkeeper and governess. She got married in

1928. In 1929 she appeared to be worried, nervous and restless. She was hospitalized for a time in a sanitarium. When admitted to the State Hospital, she appeared negativistic, belligerent, disturbed and untidy. She would tear off her clothes and frequently walk around her room entirely nude. At other times she hid her face under a blanket especially when an employee entered the room. It was impossible to change her clothes because she would bite, kick and throw trays on the floor. She needed frequent tube feedings. She often had outbursts of catatonic excitement while alone in her room. She talked constantly in a very loud manner and in a deep, masculine voice, disturbing her neighbors. Content of thought was jumbled, formless and obscene.

Patient received conservative treatment such as hydrotherapy and sedation, for five years without any improvement. In May, 1938, patient underwent insulin shock treatments. The result of these treatments was discussed by Morrow in 1938. At that time patient received 38 insulin treatments with twelve typical comas and 11 epileptiform seizures. For several months patient remained in an improved condition. However, she still displayed psychotic manifestations and remained very unstable. At first she took interest in her appearance, kept her clothing on and became tidy. She was quiet and cooperative enough to be taken outside daily for recreation. She never showed any insight into her condition. For instance, she would reluctantly accept the fact that she was in Delaware, and think that she had been married only two years. Soon she began to show a relapse. In the beginning she started to suspect that her jewelry had been stolen from her, and she accused the nurses of having her wedding ring. When her husband, who had been working in the west, visited her and told her he was going to move to the east, she was at first pleased over the prospect of seeing him more frequently but she could not understand the circumstances of the change. She frequently talked about not wanting to be a charity case. She became more and more irritable and had periods of depression. She refused food occasionally and started talking loudly in a delusional and excited manner. She would wander about the ward. No sooner had she lapsed into her psychotic state than it became very difficult to manage her. From time to time she disrobed herself, would not get out of bed and, as in the past, pulled the sheet over her head. In March, 1939, patient showed signs of untidiness and antagonism toward men.

Metrazol treatments were instituted on April 16, 1939, and, until July 28th, patient had 11 major convulsive reactions. After the 4th treatment patient showed some improvement. She became more sociable, started to eat in the dining room and helped with ward work. However, she still remained somewhat distant and paranoid toward the ward physician. During an interview she would be baffled as to why she was not allowed to go home, and why she could not have keys. She did not seem to grasp the fact that she was oblivious to many things that had occurred during her illness. Patient remained in a fairly good condition until August, 1939, when she again had a setback, and a second course of metrazol treatments was started. This treatment was continued until December 8th when she had her 23rd treatment. However, patient did not show any improvement, and in February, 1940, treatment was resumed. During the same year she had 12 treatments. Off and on she had psychotic episodes when she would talk out of the window, appear accusatory toward her roommates and require sedatives. Metrazol shock treatments were continued in 1941 and in 1942, and during that time she had 19 treatments. Altogether she had 65 metrazol treatments. It became impossible to continue the treatments because patient became frightened and resentful. Therefore, electroshock treatments were started November 18, 1942. This treatment was continued until May 9, 1946, and during this time patient had altogether 204 electroshock treatments. In addition she had two metrazol shock treatments in January, 1945. The treatment plan was clearly indicated by the episodic outbursts of disturbed behavior while during the quiet intervals the treatment practically came to a standstill.

CASE II

H. H., a white female, was admitted to this hospital for the first time in January, 1935,

at the age of 44. She improved and was paroled in April, 1935. Second commitment occurred on March 7, 1940. Diagnosis was made of Manic-Depressive Psychosis. Patient is the oldest of eight siblings. She was graduated from parochial school at the age of 18 and, after attending a business college for 16 months, worked for a large company. It was known that she was always rather quiet, reserved, somewhat seclusive and retiring. She was industrious and always tried to assume responsibility for her family. She was a poor mixer and was attached to her mother. She was highly sensitive. Since the age of 21 patient worked with a large company, appeared well adjusted in her work, and was considered conscientious and capable. The first manic attack was precipitated by the illness of her mother who suffered a sudden stroke. At first she appeared worried, started to accuse her sister and brother of selfishness and complained of their desire that the mother should die. At the same time patient was convinced that her mother's death was imminent. Patient was overactive. After a time patient became rather indifferent toward her mother and turned optimistic about her mother's health. She would call up friends by phone and boast about the remarkable improvement in her mother's health. She even made some long distance calls. Soon patient began to express the thought that everyone should support himself. She wanted to return to work. She thought that everyone in the house was insane. She became gay and carefree. She made the statement that within two months she was going to be a doctor because she took a First Aid course in high school. Upon the advice of her sister and brother, she went on a trip to visit relatives; however, it did not help much, and she became more irritable and impatient. Sleep became more difficult. She declared she had various clandestine love affairs. She changed her clothes frequently and used powder and rouge.

When patient entered the hospital, she was tense, tremulous and uncooperative. There was reduced motor activity. However, speech was overproductive, and occasionally she appeared incoherent. She showed a tendency to use silly stereotyped phrases and spoke of mysterious secrets which she promised to divulge later. She exhibited a self-satisfied attitude. A mood of mild elation was predominant. With pack treatments and sedatives she quieted down. She participated in occupational therapy classes. Following parole in 1935, she resumed her work and appeared normal in every respect. She made her home with her sister who assumed most of the responsibility for the other members of the family. She enjoyed going out and meeting people. In February, 1939, patient felt tired and was compelled to take a vacation in the country for two weeks, after which she appeared improved. In January, 1940, her sister changed her position and moved to another state. Immediately after her sister's departure patient had to assume the responsibility for the home. She became worried, apparently due to unemployment of a brother, and lapsed into a depression. She was quiet, showed psychomotor retardation, was weak and fatigued.

She was in a general hospital for several weeks and from there was transferred to the State Hospital. Patient was in a depressive state on admission, apathetic, indifferent, and incontinent. She had to be spoon-fed. Her responses were monosyllabic. She soon improved with benzedrine and continuous bath treatment, became alert, spontaneous and continent. She regained her self-confidence and participated in recreational activities, and corresponded with members of her family. In May, 1940, there was another manic attack. She became tense, restless, elated, loud, overactive and flighty. Pack treatments in the day time and sedatives at night were of no help, and patient gradually lapsed into a confused state, became hallucinated, irrelevant, noisy and incontinent. For some time she remained quiet but she never recovered from this manic attack. There was an exhibitionistic tendency. She thought that thousands of people were going to rape her. She lost considerable weight and in December, 1941, her weight was down to 80 pounds in spite of a forced feeding regime.

On December 3, 1941, shock treatments were instituted, and up until February 2, 1942, 12 electroshock treatments were given her. Then she became more cooperative although remaining untidy and mildly confused She gained weight, reaching 125 pounds. Frequent treat-

ments had to be given as she continued to show signs of relapse. Only in May, 1942, appeared patient coherent and relevant and made a better adjustment; however, she never showed any real stability. From time to time she was markedly disturbed, restless, noisy, even profane and destructive. By the end of 1942 patient had received 60 electroshock treatments. She appeared physically well, but mentally unstable, with restless and noisy episodes. Until January 24, 1946, patient had a total of 143 electroshock treatments. She would talk freely about her family. Her calculation ability was satisfactory. In February, 1946, she revealed under sodium amytal that she had always been a "perfect lady," and the more she talked about this subject the more determined was her voice. However, she did not reveal any insight. She claimed that she came voluntarily to the hospital because she was tired and worn out. She did not remember any of her disturbed periods. She expressed willingness to go back to her old job. There were no delusions or hallucinations. She was self-satisfied and thought she was perfect in everything she did. Definite hypomanic tendencies were in evidence.

CASE III

M. C., a white female, was first admitted to the State Hospital on June 2, 1927, at the age of 23. She was paroled in February, 1928. Patient graduated from parochial school and worked as a clerk since the age of 16. She was sociable, belonged to numerous clubs, was ambitious and bright. Her first attack occurred at the age of 17. At that time she was overactive, restless, and irrelevant in her talk. In 1922 she had a second attack which necessitated hospitalization for 6 months. Her diagnosis was Manic-Depresive Psychosis, Manic Type. For a while she believed that her food was poisoned, that she was doped, that she had no blood, and that she was going to be electrocuted. There was intense fear. The third attack occurred in 1927. She was in a rundown condition and lost weight, would not eat, and was subject to insomnia. She talked incessantly and became violent when opposed. She recovered with conservative treatment and was paroled in February, 1928. The opinion on the nature of her psychosis was divided, and dementia praecox was seriously considered.

In October, 1937, patient took a cruise to Cuba with her sister. During this trip she showed signs of excitement. She became overactive and remained this way during the entire journey. She drank considerably and started to talk irrelevantly. Upon her return home she went back to work but was so incapacitated that in November, 1937, hospitalization was again necessary. She remained in a hospital for a time and was transferred from there to the Delaware State Hospital in March, 1938. Here she remained in a mute state for a time and then would burst into loud, silly laughter, obscenities and irrelevant talk. She was irritable and destructive. No rapport could be established. Her facial expression was vacant. She was assaultive on numerous occasions. Hydrotherapy and sedatives did not bring about any improvement, and the impression of the attending physician was that patient was actually a case of schizophrenia.

In April, 1939, patient had a series of insulin shock treatments without any signs of improvement. She remained irrational, destructive and assaultive. At times patient appeared excited, overtalkative and destructive to clothing and furniture. There was a steady regression in behavior. Metrazol shock treatments were instituted. After the first 5 treatments patient showed some improvement. She took some interest in her appearance, even accepted her sister's visit in a friendly manner. On her own initiative she started to attend occupational therapy classes. Treatments were continued; however, after 17 treatments, patient became suddenly destructive and assaultive. At times she would talk to the physician in a friendly manner but frequently would jump out of bed and start to fight. She displayed various mannerisms, and expressed bizarre delusions. Metrazol treatments were stopped. Patient remained in an improved condition until September, 1939, when it was decided to resume metrazol injections. After more metrazol treatments patient quieted down again and became friendly and affectionate in a childish manner. She wandered around the ward and started to look at pictures in magazines without making an attempt at reading. She slept well. After having re-

ceived a total of 24 shock treatments she unexpectedly showed a marked improvement. She talked freely about her past, asked for permission to go home on weekends, and was paroled in June, 1940. Until 1943 she remained in satisfactory condition, while she was treated for menopausal symptoms. When her mother died, she became a little unstable and depressed, and frequently came to this hospital for interviews. She kept her job.

However, her adjustment was superficial. In 1945 one of her sisters became ill and died. Patient soon became depressed and accusatory, calling her sisters indifferent and inconsiderate. She began to talk irrationally. She was readmitted on December 6, 1945, and after the 16th electroshock treatment she began to talk spontaneously and was more observant. After her 22nd treatment patient showed satisfactory emotional response and she was allowed to go home on weekends. She was again paroled January 26, 1946. On February 4, 1946, patient voluntarily returned to the hospital. She appeared excited, morose, resented shock treatments and displayed paranoid tendencies. She even threatened to kill physician if he resumed treatments. Until May 13th patient had a total of 55 shock treatments, effecting no permanent improvement. She has a habit of talking to herself and is occasionally loud but her general conduct is more agreeable. On February 10, 1945, she had a sodium amytal interview during which autistic elements were revealed. The impression was gained that she showed a schizophrenic reaction.

CASE IV

E. T., a 22-year-old white female, showed peculiarities in childhood. She would not go outdoors unless accompanied by someone because she was easily frightened by boys. At the age of 10 or 11 patient had night terrors and would remain in her mother's bedroom. At school patient was at first extremely shy and asocial. However, the shyness gradually diminished, and she made a fairly good adjustment. In 1941 she entered college. At the age of 14 she had difficulty in falling asleep and had the habit of keeping the window shades down and the doors closed. She became more irritable, tense, apprehensive, and impudent with members of her family. She admitted that she was subject to worrying and day-dreaming. After entering college she made a poor adjustment and complained that one of her teachers was making homosexual advances toward her. She was upset for a while but, after she was taken out for a short time to visit an uncle, she calmed down and returned to college. Off and on she would show signs of depression and talk about the college situation in a derogatory manner. Finally she became hallucinated in the auditory sphere, paranoid, confused and panicky.

She was admitted to a psychiatric hospital on October 20, 1943. There she was seclusive, stared blankly, laughed without reason, was uncommunicative and hallucinated in the auditory sphere. She expressed ideas of influence, and made the remark that she was bothered by a lot of "corny women psychologists." Diagnosis was made of Schizophrenia, Paranoid Type. Insulin shock treatments were instituted. She had a total of 82 treatments with 72 periods of stupor. In addition she had 9 metrazol shock treatments during the course of insulin. No improvement was noted. Patient remained silly, at times sullen and hallucinated. She heard a man's voice who talked to her and made love to her. On April 9, 1945, she was admitted for further study and treatment. At that time she was uncooperative, untidy, showed a marked tendency toward blocking, displayed mannerisms and grimacing. On April 17, 1945, electroshock treatments were started. At first she had a tendency to resist considerably to these treatments but soon she appeared more cooperative. After 42 treatments patient volunteered some information about her past. She described pseudo-hallucinations of the auditory variety which she explained as projection of her own thoughts in the form of questions and answers. However, she was preoccupied with sexual delusions based on abnormal sensations. Until May 13, 1946, she had reached a total of 70 shock treatments. At present she appears much improved, however, without attaining full remission.

CASE V

A. B. was committed to this hospital on September, 10, 1953, at the age of 63. She is a high school and business college graduate. Normally she was reserved, oversensitive,

easily hurt, and quick tempered. Her interests were limited to reading and church activities. She took great interest in her home. At the age of 46 she got married to a man 14 years her junior, whose low socio-economical standard and strong religious bend were a source of preoccupation and conflict. Patient was eager to have children. However, she declined to have an operation to make pregnancy possible. Immediately after her marriage, patient had short attacks of depression. In 1931 she lapsed into a depressed stupor which called for her admission to a mental hospital. She improved somewhat within 6 weeks. The symptoms displayed were not entirely characteristic of depression. She was overactive, negativistic and talked excitedly in a rambling and incoherent fashion, showed marked emotional swings, and was hallucinated in the visual sphere. She appeared confused. Within two weeks she quieted down and developed some insight. She did no longer express any self-accusatory ideas. Between 1934 and 1935 patient's condition necessitated hospitalization on three different occasions. In 1942 patient was again hospitalized in a sanitarium on account of depression. She remained there for 7 weeks but upon her return home she lapsed again into a depressed and agitated state. She was assaultive toward her husband, and threatened him with a knife.

Her treatment consisted of convulsive therapy, but was followed only by temporary improvement. She was later transferred to our hospital in an extremely agitated state. She had frequent crying spells, was preoccupied with ideas of death and suicide. She gave very little information about herself. At times she was incoherent in her responses. She soon became assaultive. On frequent occasions she kicked employees, or threw dishes in the dining room. Pack treatments were of little help, and on Sept. 17, 1943, electroshock treatments were instituted. After the 5th treatment she became more cooperative. Her appetite was good. She appeared more cheerful and talked fairly coherently. She participated in occupational therapy classwork. However, she still expressed the thought that nobody loved her, and that her husband was much older than she. After the 12th treatment she became confused, and treatments had to be temporarily discontinued. This confusion subsided within two weeks. Thereafter she became coherent and relevant, talked fluently but wrote distorted letters home. It was evident that she had not entirely recovered. Patient again became despondent, agitated and uncooperative. From Sept. 17th until Dec. 29th, 1943, she had 22 shock treatments. In January, 1944, treatments were resumed, and up to Feb. 16th she had a total of 33 treatments. In February, 1944, metrazol shock treatments were started and during the year patient had 37 such treatments. In addition she had, in 1945, 88 electroshock treatments. From Oct. 12, 1944 to Nov. 3, 1945, she had a total of 158 shock treatments (metrazol plus electroshock). This patient is calmer and quieter, cooperative, is sleeping and eating well and has gained weight. She shows some impairment of memory. Her age level and the possibility of organic complications seem to preclude a more favorable outcome.

CONCLUSION

The application of prolonged electroconvulsive therapy to the just described and numerous other chronic patients was dictated as an emergency measure under difficult circumstances, yet there are many reasons why this method is going to stay. The risk of regression is too serious in many instances of chronic psychosis to stand by idle or to rely on conservative regimes which, more often than not, give little satisfaction to the patient and no encouragement to the physician. There are still too many unknown factors about the basic principles involved in this method, and it is sincerely felt that it is still in the stage in which the experimental attitude of the therapist is an asset. Moore, and Kalinowski and Hoch have described as maintenance treatment a method of application designed to keep the optimal level of improvement in cases which do not enter into permanent remission.

We believe that electroshock therapy can and should be expanded to such chronic cases in which a tendency to intermittent or periodic exacerbations exists. There is ample justification in such procedure, and the following points deserve serious consideration:

(1) Resistance to therapy of one or the

other form has been established on previous experience, or

(2) at times, the patient is admitted for further treatment after several previous therapeutic endeavors in the acute phase have failed.

(3) Physical impairment due to unfavorable attitudes of the patients can be forestalled (poor food intake, refusal to eat, need for tube-feedings, or parenteral fluid administration).

(4) Sedative therapy cannot be pushed beyond the critical level, and overdosage can be easily avoided.

(5) Violent outbursts can be more readily held in abeyance while the actual risks to life and property are reduced to a minimum.

(6) Mechanical restraints can be limited or entirely abandoned.

(7) There is still the potential element of unexpected gains.

(8) In our experience, no evidence of permanent impairment of mental faculties as a result of prolonged treatment has been adduced, and there was not a single serious accident among the large group of chronic patients thus treated.

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VERBAL POLARITY IN DEMENTIA PRECOX

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Farnhurst, Del.

It is becoming increasingly evident that objective psychometric methods are of great value in the psychiatric analysis of mental disease and personality abnormalities. Exact laboratory techniques not only confirm clinical impressions but increase the possibilities of fine intra-individual differentiation impossible to attain with traditional clinical observation. Karl Menninger points out in his introduction to Rapaport's book that "with the advent of the newer methods in psychological testing, psychiatry has come of age in the scientific world" and "that the psychological laboratory has become indispensible to the clinical psychiatrist." He goes on to say: "In those early groping days of psychometry when psychological testing meant only the more specific measurement and description of intelligence, it was understandable that psychiatrists found it of minor value, useful only in cases of borderline mental deficiency. But that was a long time ago, as time is measured today. Psychological testing has come a long ways since then. It has come further than many psychiatrists realize.

It is the department of mental science in which the greatest relative progress has been made in recent years." "The matter of results justifies a few additional words. I think many psychiatrists give only lip service to the importance of the psychological laboratory and of psychological testing because they are not wholly convinced of the validity of the newer psychological test indications. . . . but our experience here has shown time after time that the psychological test results point to more (or less) malignant condition than clinical observation had led us to suspect and further observation has usually proved the psychological tests correct." "I cannot express my own endorsement of this book more strongly than to say that I believe that the practice of psychiatry without the assistance of modern psychological testing . . . is as old-fashioned and out of date as would be the practice of orthopedics without the X-ray." Menninger's enthusiasm about psychological tests is shared by the present writers, but not without certain reservations. When he speaks of the newer methods of psychometric analysis, he has in mind the inter-individual and intra-individual interpretation of test results. In the old days the results from many different tests were added and averaged to yield one I. Q. The more recent approach to test interpretation is to regard test results as the outcome of the total personality of the patient.

For example, when an individual obtains a vocabulary quotient of 120 and an arithmetic quotient of 65, the two values are not averaged but their relationship carefully investigated and its meaning in regard to the patient's problems fully explained. The modern practice consists of studying many such relationships derived from a large number of

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heterogeneous test scales. The central question is not to find out whether the patient is dull or smart but to determine what personality factors cause these striking and scientifically useful discrepancies in adjustment found almost daily in abnormal individuals. Averages obscure precisely what the clinician is looking for. On the contrary, analysis of the spread and distribution of many test quotients reveals the nature and degree of mental dysfunctioning. Such studies increase the diagnostic accuracy beyond anything known to psychiatry in past decades. They also make psychometry the science of the individual in all his complexity. Each person is a law unto himself and each psychometric pattern is as distinctive and meaningful as is the behavior pattern under investigation. No two persons are alike when viewed in terms of their test constellations. The complete individuation of test results does not excuse the psychologist from organizing his thinking into practicable and diagnostically useful concepts of the human mind. It is impossible to comprehend the numerous variations and permutations of objective test findings without a theory of the whole personality.

The weakness of most studies in psychometric pattern analysis lies in the fact that they fail to provide an acceptable theory of human intelligence and character. They are too opportunistic and still too intuitive. A further difficulty in the accurate analysis of test patterns is the choice of the validating criterion. Babcock, Rapaport, Wechsler and numerous other experimenters have used psychiatric classifications of mental illness as the starting point for their psychometric researches and as a comparative norm for their findings. The value of their conclusions is thus marred by the limitations of current psychiatric ideas and nomenclatures. Few psychiatrists believe that their groupings of mental ills have a sound basis in scientific observation. Psychometry as a science cannot possibly advance by reference to systems of thought which are less scientific than itself. Like astronomy, physics and chemistry, psychometry must develop its own intrinsic criteria of comparison which will be applicable to all humans, sick and well. It must and can influence psychiatric thinking in such a way as to modify and eliminate useless and impracticable concepts of mental disease. Otherwise it merely perpetuates that which is inaccurate, unscientific and untenable in psychiatry. It can be most helpful to psychiatric progress only when it develops a comprehensive theory of the total personality by the observance of factual interrelationships extracted from its well-controlled experimental designs. Psychiatric systems of mental classifications will become outmoded only after psychologists improve their psychometric systems far beyond the stage of present-day pattern analysis.

In current investigations the emphasis has shifted from the determination of intelligence to the analysis of mental illness. What is really needed is the exact determination of all mental factors influencing human behavior, including intelligence, sanity, temperament, volition, and all the other personality traits known to exist. When the accurate measurement of the important mental factors is accomplished, psychometry will become truly indispensible to psychiatry. Classifications of mental illness will then be expressed in terms of multiple but readily understandable indices and not in terms of vague descriptive categories. Mathematical expression of several primary facets of the personality will take care of the common overlapping found between the various groups and classes of mental illness as conceived nowadays.

It has been known for almost forty years that in mental illness the vocabulary test is less vulnerable than are most of the other tests employed in clinical practice. Babcock has demonstrated some years ago that patients suffering from general paresis and from dementia precox have usually higher vocabulary ratings than memory ratings or manual performance ratings. Jastak has shown that the same relationship prevails in children with behavior disorders. It is a common observation that practically all verbal tests are less affected by the aberrations of mental disease than are tests which require the learning of new impressions and the planning of manually executed performances. This phenomenon has led to the practice of considering the vocabulary test a valid tool for the measurement of the pre-psychotic intelligence level of the patient. It has also been used for the estima-

tion of the degree of mental disorganization. Thus, if two patients have vocabulary quotients of 100, they are usually diagnosed as being of average intelligence regardless of the value of other test ratings. If the performance quotient of one patient is 76 and of the other 63, the latter is considered more disorganized than the former. In many cases it is entirely legitimate to assume that the greater the difference is between the vocabulary rating and some sort of efficiency rating the more severe is the mental disturbance. But this is not always so. The verbal concept-efficiency theory is based on at least three unverified assumptions. If the assumptions are correct, the theory and the clinical practices based on it are valid. If the assumptions are incorrect, the clinical interpretations it favors must be abandoned in favor of more universally acceptable procedures.

The assumptions underlying the Babcock theory are as follows: (1) The vocabulary test is not appreciably influenced by the disturbances of psychotics or if it is, the effect is a uniform or constant one in all cases. (2) The vocabulary test is a valid technique for the measurement of intelligence. (3) Memory tests, manual performances and other vulnerable tests are predominantly tests of mental efficiency rather than intellectual capacity. Clinical experience and precise measurements seem to indicate that each one of these assumptions is correct only in a small minority of cases and that therefore the Babcock method may not be used reliably for the study of either intelligence or sanity. The vocabulary test is often strongly affected by mental disturbances. The vocabulary test correlates with intelligence only imperfectly. In this it resembles all other tests including the so-called efficiency tests. The so-called efficiency tests are frequently better tests of original intellectual capacity than is the vocabulary. The identification of the extent of one's word knowledge with intellectual endowment is popular for two reasons. The vocabulary test yields one of the most reliable and most consistent psychometric measures.

The vocabulary and similar verbal tests have the dubious distinction of measuring what is known as abstract intelligence. It is a fact that a highly reliable test is also a valid test. What remains to be done is, of course, the establishment of the nature of its validity. How valid is the vocabulary, or any other test for that matter, in the determination of intelligence? How valid is the vocabulary test in the study of temperament? How valid is the vocabulary test in the estimation of emotional stability? How valid is the vocabulary test in the analysis of human motivation? How valid is the vocabulary test in assays of schooling and education? How valid is it in the measurement of mental deterioration? How valid is it in estimates of specific verbal ability or neural polarity of the individual? If we assume for one moment that the vocabulary test is affected by all these variables, then it cannot be legitimately employed as a reference point for the calculation of efficiency indices or deviation ratios to investigate the personality organization of the patient.

Even if we admit that the vocabulary test is a very reliable and valid psychometric tool, we need not imply that its validity is limited to any one of the above-mentioned factors. Verbal tests are no better tests of abstract intelligence than are form board tests, drawing tests, picture tests, memory and attention tests. Intellect, sanity, temperament and will power have varying media of expression in different individuals. Mental disorganization is sometimes measured best by one test and sometimes by a totally different test. Intelligence is best determined by the use of different ratings in different persons. The mental capacity of human beings is expressed through many different channels. Sometimes the vocabulary test expresses it most adequately, sometimes arithmetic, sometimes verbal comprehension and reasoning, sometimes manual activity and sometimes social adjustments. Each individual has his own distinctive medium of expression. The distribution of the most favored media of expression is random. Therefore every test is as good as every other test in measuring the native endowment of people.

The inadequacy of the verbal concept-efficiency idea has led some psychologists to search for new methods of expressing and interpreting the inter-test discrepancies of psychometric examinations. Wechsler, for example, suggests the use of the mean of all test

scores as the reference point from which the numerous test deviations may be calculated. The mean of many test ratings or quotients is an extraordinarily stable statistic. Its great mathematical reliability lends itself to the extraction of numerous deviation constants. Unfortunately these constants along with the means from which they are calculated are devoid of psychological meaning. The mean of many psychological ratings is a thoroughly heterogeneous value. It conceals within itself a multiplicity of undifferentiated effects. It is contaminated with all the variables that are to be isolated and measured in sensible and workable diagnosis.

Here is a practical example of the impracticability of the mean-deviation method. A patient receives the following twelve quotients from twelve different, reliable scales: 96-72-68-67-67-65-64-64-64-63-62-58. The patient is obviously psychotic and severely disorganized. The mean of all his tests is 67.5. The deviation ratio obtained by dividing the lowest score by the mean, to take only one instance, is 86. If applied to the general run of psychotic cases this value of 86 is quite high, indicating a perfectly normal personality. In reality the patient is more disturbed than most psychotics. Cases of this sort are so common in ordinary clinical practice that the mean-deviation ratio or mean-test difference is of little value in aiding the psychiatrist in clarifying his ideas about the capacity or the mental condition of the patient. The first and foremost condition of a valid pattern analysis lies in the postulation of clear-cut, easily identifiable psychological traits. Purely statistical devices, no matter how reliable, will not do. If averages are used they must have a psychological rationale which insures homogeneity of the resulting score.

If the tests in a battery of twelve scales are reliable, their scores are equivalent in their psychological significance. The range of scores, from the highest to the lowest, is in fact more important than is the average of all tests. The highest rating, regardless of the test, is no less important than is the lowest rating. It represents the least vulnerable item in any one individual. Any test whatever may assume the position of the least sensitive item as far as the psychosis or the abnormality is concerned. Vocabulary, reading, arithmetic, recall, picture reasoning, form boards will in different persons take the first position in comparison with the achievements of a random sampling of the population. This highest rating or perhaps the average of the highest three ratings, if statistical reliability is wanted, will be closer to the potential capacity of the individual than all the remaining ratings. It reflects the person's level of highest mental integration which is the most accurate operational definition of intellectual endowment. It also serves as the most valuable intrinsic criterion from which all characterological or non-intellectual deviation ratios may be computed. The deviations from capacity fall into several congruous test clusters corresponding to several independent personality traits. Thus the measurement of several primary character traits becomes a distinct possibility. The definitions and methods of clinical measurements of these traits will be described in detail in a forthcoming volume by one of the writers.

In this paper we are concerned with one of the non-intellectual factors which we call the polarity of the human mind. It controlls the laterality orientation of the patient and with it the language aptitudes observable in people generally. This verbal polarity is found to be uncorrelated with intellectual capacity. This means simply that intellectually average or even superior persons may be deficient in vocabulary and in all the verbal functions measured by related verbal tests. Conversely, some intellectually inferior individuals may be relatively more adequate in the language functions than are intellectually average or superior individuals.

We shall confine ourselves only to the measurement of native endowment and of neural polarity, though other personality traits may be readily measured by the method here proposed. The tool used for this purpose is an experimental scale of twelve sub-tests developed during fifteen years of experimentation in the psychological laboratory. The battery is called the "Psychometric Patterns." It includes vocabulary, oral reading, information, analogies, comprehension, digit recall, mental arithmetic, picture anomalies, picture reasoning, symbol substitution, drawing and form boards. These tests have been

found to be far more reliable due to improved administration and scoring than most psychometric scales in current use. Our demonstration will be on forty cases of dementia precox. Any other group of psychiatric cases could have been used with equally good results. It can also be used on normal samplings of the population.

The capacity scores of the forty cases of dementia precox are calculated by averaging the three highest quotients regardless of the nature of the tests falling in these positions. When this is done in a random sampling of normal persons the correlations between capacity scores and tests range from .42 to .58 with an average correlations coefficient of about .50. Thus intelligence or the maximum level of mental integration accounts for only about 25% of the total variance of human achievement. Our capacity factor is closely related to the general factor of Spearman isolated over forty years ago and also to Thurstone's general (first unrotated) factor which is invariably present in all multiple factor analyses. The average capacity score of our group of 40 dementia precox cases selected at random is 99.6. The range of capacity scores varies from 64 to 136. There are no significant differences in capacity between the various sub-groups of dementia precox. Whether they are paranoid, catatonic, hebephrenic, simple, mixed or undetermined, their capacities tend to be average with a suggestion of normal variability of scores below and above the average. This is as it should be, because the condition of dementia precox occurs at all levels of capacity. The native endowment of those suffering from dementia precox is independent of the manifestations of their insanity. Insanity has no effect whatever on the intellectual capacity of men. It does affect certain achievements, abilities and adjustments, but it does not lower intellectual altitude as is commonly believed. The observed disorganization is not intellectual, but characterological. Character traits are in turn independent of capacity. They may occur in various amounts and combinations in the genius as well as in the imbecile.

Verbal polarity is revealed by the deviation clusters from capacity of five tests of the psychometric patterns. These are vocabulary, reading, information, analogies, and comprehension. The deviation ratios are calculated as follows. The standard scores (M 100, S. D. 16) of the five tests are found. Suppose these are 82-91-93-97-105. Only the median three scores, in this case 91-93-97, are averaged. The average is 93.67. This value is divided by 107, the capacity rating of the patient. The resulting quotient is 87.54 which, if transmuted into a standard score, is exactly 100. The verbal polarity of this patient is therefore average. If we had used the vocabulary rating of 82 as the patient's intelligence quotient, we would have underestimated his capacity by fully 25 points. This is what actually happens in many cases in which the Babcock system of test analysis is employed. It should be pointed out that the polarity score is derived from a different cluster of tests in each patient. This principle of factorial diversification is one of the most important discoveries of clinical psychology. It applies to the measurement of capacity as well as to the objective isolation of all other personality traits. Verbal aptitude and language development are largely independent of native capacity. The bright infant may be late and defective in articulate speech. The moron may be as good in his language abilities as his capacity permits. Reading and spelling disabilities occur at all levels of intelligence. Orton's developmental motor apraxia is randomly distributed at all intelligence levels. The correlation between our polarity scores and capacity scores is within the probable error range of zero in a random sampling of any age group. The average polarity rating of the whole group of dementia precox patients is 99.1. All subgroups of dementia precox tend to have average polarity ratings, 95-102. The average polarity ratings of the various capacity levels in our group are similar.

Capacity Level	Average Polarity	Number of Cases
120 - 140	104	7
100 - 119	98	12
80 - 99	99	17
60 - 79	102	4

This is another way of stating that verbal polarity may be high in cases of low capacity and unfavorable in cases of high capacity.

Superior intellect may be associated with inferior or superior verbal ability. In most cases it is average. Most cases of average intelligence have also average polarity scores. The distribution of capacity and polarity quotients approximates normal variability in the general population. In our demonstration group the incidence of both ratings is as given below.

Standard Scores	Capacity N	Polarity N
Below 70	2	3
70 - 79	2	2
80 - 89	8	7
90 - 109	17	15
110 - 119	4	9
120 - 129	4	3
130 - 139	3	1

Verbal polarity as herein defined and measured is an independent and primary mental trait of the non-intellectual variety. It depends on neural organization and not on the brain power of the individual. The ability to express oneself in language is no more intellectual than is the ability to comprehend and to employ spatial abstractions. Block constructions are as good a test of intelligence as is the vocabulary test. Many persons are inferior and deficient in vocabulary from early infancy on despite good mental capacity. The vocabulary test, invulnerable though it is in the examination of psychotics, may not be used as a valid reference point for the derivation of factorial scores or of clinically meaningful personality scores. Deviations from the mean yield psychologically impure test patterns which are of little or no value in the experimental study of mental disease. A random sampling of psychotic individuals of all classifications are of average intelligence. This experimental finding is in harmony with common sense observation. Sanity and intelligence are independent psychological entities. Their incidence is random in the general population. One has no effect on the other, but both determine success and achievement in life situations as in tests. Sanity is not a homogeneous mental trait, but may be analyzed into various components by appropriate psychometric methods.

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OPPOSES MERGER OF VOLUNTARY HEALTH AGENCIES

In a statement strongly opposing recent attempts to merge the nation's 20,000 voluntary health agencies D. B. Armstrong, M. D., Sc. D., of New York, says that it is a move toward the "destruction of American institutions of freedom."

Writing in the June 15 issue of *The Journal of the American Medical Association,* Dr. Armstrong disclaims responsibility of the National Health Council for the recommendations issued in the Gunn-Platt report in 1945. The report, directed primarily to professional public health workers, recommended a complete reorganization of the national voluntary health agencies and the pooling of their fund raising efforts.

Although technically the study was made under the auspices of the council, Dr. Armstrong, a former president and first executive officer, says that the recommendations should be credited solely to Selskar M. Gunn, C. P. H., and Philip S. Platt, Ph. D., grantees of the Rockefeller Foundation.

The Gunn-Platt report urges, among other things, the establishment of a health council in every community representing a voluntary unification of all local health societies. The report deplores the lack of central direction and planning and duplication of effort; it urges that present separate money-raising appeals be coordinated into a nation-wide campaign and asks that the two agencies with the

most effective money-raising devices — the tuberculosis and infantile paralysis groups— broaden their fields of interest and service.

History indicates, the author says, that this effort, the third of its kind, urging consolidation of the independent health organizations, will fail. Dr. Armstrong states that "indeed, the primary objective of the council in the early 1920s was merger. While many other things attempted succeeded, merging failed completely. In the mid 1930s another major effort at amalgamation into one agency was made and again failed. Both those attempts were direct and honest approaches and convinced some participants and observers, at least, of the futility and lack of wisdom of the effort. Now, through the Gunn-Platt study and report, a third indirect and more devious approach is being made, this time working from the periphery inward. It is our opinion that this too is doomed to failure and that the idea is now 'going down for the third time.' The next time it is fished out of the roiled waters it should, it is to be hoped, be recognized as 'a dead cat.' "

Some of the facts and fallacies which have led the author to the conclusion that merger is both improbable and unwise follow in part.

Facts:

"1. It is a fact that the national voluntary health agencies can do and are doing advantageously certain things in common. These include not only common mechanical services such as rentals, accounting, supplies, telephone service, shipping and library, but also many other mutual interests which can, to a degree at least, be best served in common, such as certain phases of research, the development of health educational activities, personnel recruiting and management, statistical services, certain phases of state and local field organization and control and increased cooperation with non-member organizations.

"2. It is a fact that resources for the several important voluntary health movements are uneven. This is of course inevitable. It is easier to raise money for infantile paralysis, for instance, than it is for venereal disease control. It is probable that there are important causes such as venereal disease control that will always need special help and that cannot raise funds as adequately by popular appeal as do the infantile paralysis, tuberculosis, cancer and other movements. Venereal disease efforts may have to find their chief support from large givers, or arrangements might be made whereby they could share in the more generously financed movements.

"3. It is a fact that previous efforts at voluntary health consolidation failed, and for inherent, basic reasons. Such a unification on the national level would be contrary to the American tradition and possible only in a regimented society.

"4. It is a fact that there are in our country two kinds of people who want the consolidation of voluntary health agencies and who are willing to sacrifice freedom to regimentation with the object of economy, efficiency and more complete control. The first group is composed of that portion of the social workers, statisticians and community organizers who are communistically inclined. The other group is made up of business executives who favor a unification of appeals, who like the local community chest idea because it means fewer requests for appropriations and because it means that actually in most instances they and their business will have to give less in total than they would if faced with a number of separate demands. Actually these two groups have the same collective ideology and the same desire for organized monopoly."

Fallacies:

"1. It is a fallacy to assume that the public is averse to multiple agencies. The individual citizen generously supports the agency or agencies in which he is especially interested, often because of some personal or family experience. During the last few years, when the public was supposed to be consciously overburdened and annoyed, agencies have developed more rapidly in number and volume than in any equal prior period. Never were so many new programs launched. Never have separate movements met with such generous financial support from the public. The tuberculosis seal sale reached an all time high in 1945. The infantile paralysis control movement has grown by leaps and bounds. Two separate national cancer drives within the last two years have raised approximately $8,000,000,

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+ Editorial +

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AT LAST

The American Psychiatric Association, representing about 4,000 psychiatrists throughout the United States and Canada, at its Annual Meeting in Chicago, May 25 - May 30, passed the following resolution.

1. "To set forth the actual status of mental hospital care of patients throughout the country.

2. "To state the reasons why deficiencies have always existed and have been aggravated by war conditions.

3. "The American Psychiatric Association will support and take immediate steps to give effect to the last three paragraphs in the report of May 26, namely;

"The Committee is in favor of the American Psychiatric Association assuming its rightful leadership, by taking more positive and aggressive steps for achieving success in its endeavor.

"The American public will not consider psychiatry as a legitimate scientific branch of medicine as long as mental patients are treated in institutions with a cost of a minimum of sixty-five cents per capita per diem and a maximum cost of two dollars per capita per diem.

"The Committee believes the American Psychiatric Association should become more realistic and demand that every state mental hospital consider a minimum of five dollars per capita per diem necessary for the care and treatment of acute, sub-acute and convalescent cases and two dollars and fifty cents per capita per diem for the care of various types of chronic cases.

4. "The Council will set-up machinery for the inspection and rating of all mental hospitals; and to bring to the attention of all state authorities deficiencies requiring correction.

5. "The Council is also of the opinion that by supporting wholeheartedly the Psychiatric Foundation the aims of psychiatry as outlined will be greatly advanced by the collaboration of lay and professional groups.

6. "That the American Psychiatric Association urge general medical and surgical hospitals to include in their plans for development a psychiatric inpatient service. Such publications as the "Modern Hospital" should be requested to carry an editorial on this matter in one of their early issues.

"Furthermore, that the Council of the American Psychiatric Association take the initiative in gaining the cooperation of the American Medical Association and the American Hospital Association in joint support of this recommendation.

7. "To authorize the Secretary of the American Psychiatric Association to send copies of these resolutions to the authorities of each state requesting them to consider the above paragraphs prerogative for future improvement of mental hospitals."

It is our opinion that every physician in this state should wholeheartedly approve the above and fully support the new approach of the American Psychiatric Association in regard to the standards and policies of psychiatric hospitals and out-patient clinics.

OPPOSES MERGER OF VOLUNTARY HEALTH AGENCIES

(*Concluded from Page 137*)

and another one is now being terminated for an even larger amount.

"2. It is a fallacy to claim that the trend is all toward consolidation. . . . In reality, the trend on both the national and the local level is definitely away from consolidation.

"3. It is a peculiarly silly fallacy that the amount of funds that the public will make available for voluntary health effort can be increased by burying the special appeals in an anonymous approach. . . . It would be fatal for the voluntary health agencies to give up their independent, free access to public support.

"4. It is said, we believe fallaciously, that socialization in medicine and public health is inevitably coming on a national scale as regards official activities, and that a parallel development is therefore essential in the voluntary field. This is a two-barreled fallacy, and the trigger is pulled by the same individuals. The same small group of persons are pushing the socialization idea through both official and voluntary channels. They work behind the scenes for the destruction of American institutions of freedom. It is important that their aims and activities should be understood by us all."

'COLD WAVE' REACTION

An acid used in the process of hair curling known as a "cold wave" has been found to produce symptoms of poisoning in allergic and anemic persons, according to Lawrence H. Cotter, M. D., of New York.

Writing in the June 15 issue of *The Journal of the American Medical Association,* Dr. Cotter, who is from the Department of Medicine, College of Physicians and Surgeons, Columbia University and the Presbyterian Hospital in New York, says that the "cases in which a toxic reaction has been observed appear to be on the increase."

The author attributes the recent increase in cold wave poisoning to the fact that the "process is more widely advertised, and cheaper, with the result that less skilled operators now employ it. Its former high price confined its use to a small clientele in the better class establishments."

Experience with patients having thioglycolic poisoning indicates, the author says, that "persons suffering from allergies and anemias are the most likely victims, but the acid has an established affinity for the protein molecule, and liver damage to some extent may be anticipated from prolonged exposure in any individual." However, in the majority of cases recovery occurs without permanent liver damage when the exposure is promptly terminated.

Thioglycolic acid has been used in industry as an iron indicator with no reported ill effects on the handlers.

Some of the major symptoms noted among the patients have been swelling of the face, arms and legs, appearance of an itching rash, and loss of hair.

Dr. Cotter warns that "at the present time an outfit for home use has been out on the market, and it should be recognized as a danger in unskilled hands, and even in skilled hands to a certain proportion of the beauty seekers."

Among the several case histories cited by the author is one of a 52-year-old woman who "had not handled any thioglycolic acid preparation but had a 'cold wave' of her own hair. As soon as the acid solution was applied she felt an intolerable burning sensation, which persisted for three days in spite of all attempts to wash off the acid. She also had severe cramps and itching all over the body." A week after receiving a second patch test from her doctor she had swelling of the hands and feet and enlargement of the armpit lymph nodes, as well as the itching and burning, and her hair came out in large patches.

When seen in the laboratory, this woman had dark patches on her skin and denuded areas on her scalp. She appeared emaciated and nervous. Eventually, the author says, "her symptoms cleared up except for an intermittent burning sensation of the scalp."

The author concludes: "Now that this product is being sold in the chain stores, its indiscriminate use will result in an increased incidence of poisonings, many of which are already finding their way to the courts. Adequate labeling and understanding of the dangers involved are imperative."